Physician Consent Form

Fax to Christi Gleason, Fitness Supervisor
at 314.290.8517 or email cgleason@ci.clayton.mo.us

Date_____

Physician referral requested by certified personal trainer _____

Client _____ Phone _____

Physician _____ Phone _____

Your patient has requested to participate in a physical activity program. This request is for the purpose of establishing medical clearance to provide recommendations for beginning an exercise program. Due to the following risk factors, I am requesting medical clearance for your patient. Please complete the following form to indicate any recommendations that would currently affect participation in the testing procedures or physical activity program. The client has signed a statement that it is his/her responsibility to inform the trainer of any changes in their health status.

Primary Risk Factors:

_____ Elevated Cholesterol	_____ BMI >30	_____ Family History	_____ Cardiovascular Disease
_____ Sedentary	_____ Cigarette Smoking	_____ Pregnancy	_____ Cardiovascular Disease
_____ Age	_____ High BP/BP meds	_____ Metabolic Disease	_____ Muscle/Joint Problem

signs or symptoms _____

I recommend the following:

____ Client may participate fully in a physical activity program.

____ Client may participate in a physical activity program with the following restrictions: _____

_____

_____

____ Client may **not** participate in any physical activity program at this time.

Physician's Signature _____ Date _____

The Center of Clayton
50 Gay Ave
Clayton, MO 63105